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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2014

A N A C T

RELATING TO INSURANCE

Introduced By: Senator Gayle L.Goldin

Date Introduced: February 27, 2014

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Section 27-18-61 of the General Laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" is hereby amended to read as follows:

27-18-61. Prompt processing of claims. -- (a) A health care entity or health plan operating in the state shall pay all complete claims for covered health care services submitted to the health care entity or health plan by a health care provider or by a policyholder within forty (40) calendar days following the date of receipt of a complete written claim or within thirty (30) calendar days following the date of receipt of a complete electronic claim. Each health plan shall establish a written standard defining what constitutes a complete claim and shall distribute this standard to all participating providers.

(b) If the health care entity or health plan denies or pends a claim, the health care entity or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing the health care provider or policyholder of any and all reasons for denying or pending the claim and what, if any, additional information is required to process the claim. No health care entity or health plan may limit the time period in which additional information may be submitted to complete a claim.

(c) Any claim that is resubmitted by a health care provider or policyholder shall be treated by the health care entity or health plan pursuant to the provisions of subsection (a) of this section.

(d) A health care entity or health plan which fails to reimburse the health care provider

or policyholder after receipt by the health care entity or health plan of a complete claim within the required timeframes shall pay to the health care provider or the policyholder who submitted the claim, in addition to any reimbursement for health care services provided, interest which shall accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a complete written claim, and ending on the date the payment is issued to the health care provider or the policyholder.

(e)(1) A health care entity or health plan shall not deny payment for a claim for medically necessary inpatient services resulting from an emergency admission provided by a hospital solely on the basis that the hospital did not timely notify such health care entity or health plan that the services had been provided.

(2) Nothing in this subsection shall preclude a hospital and a health care entity or health plan from agreeing to requirements for timely notification that medically necessary inpatient services resulting from an emergency admission have been provided and to a reduction in payment for failure to timely notify; provided, however that: (i) Any requirement for timely notification must provide for a reasonable extension of timeframes for notification for emergency services provided on weekends, state, or federal holidays, or during declared state or federally declared states of emergency; (ii) Any agreed to reduction in payment, for failure to timely notify, shall not exceed the lesser of two thousand dollars ($2,000) or twelve percent (12%) of the payment amount otherwise due for the services provided; and (iii) Any agreed to reduction in payment for failure to timely notify shall not be imposed if the patient's insurance coverage could not be determined by the hospital after reasonable efforts at the time the inpatient services were provided.

(f) Except where the parties have developed a mutually agreed upon process for the reconciliation of coding disputes that includes a review of submitted medical records to ascertain the correct coding for payment, a hospital shall, upon receipt of payment of a claim for which payment has been adjusted based on a particular coding to a patient including the assignment of diagnosis and procedure, have the opportunity to submit the affected claim with medical records supporting the hospital's initial coding of the claim within thirty (30) days of receipt of payment. Upon receipt of such medical records, the health care entity or health plan shall review such information to ascertain the correct coding for payment and process the claim in accordance with the time frames set forth in subsection (a) of this section. In the event the health care entity or health plan processes the claim consistent with its initial determination, such decision shall be accompanied by a detailed statement in plain language of the health care entity or health plan

setting forth the specific reasons why the initial adjustment was appropriate. A health care entity or health plan that increases the payment based on the information submitted by the hospital, but fails to do so in accordance with the timeframes set forth in subsection (a) of this section, shall pay to the hospital interest on the amount of such increase at the rate set pursuant to subsection (d) of this section. Neither the initial or subsequent processing of the claim by the health care entity or health plan shall be deemed an adverse determination if based solely on a coding determination. Nothing in this subsection shall apply to those instances in which the insurer or organization, or corporation has a reasonable suspicion of fraud or abuse.

~~(e)~~ (g) Exceptions to the requirements of this section are as follows:

(1) No health care entity or health plan operating in the state shall be in violation of this section for a claim submitted by a health care provider or policyholder if:

(i) Failure to comply is caused by a directive from a court or federal or state agency;

(ii) The health care entity or health plan is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(iii) The health care entity or health plan's compliance is rendered impossible due to matters beyond its control that are not caused by it.

(2) No health care entity or health plan operating in the state shall be in violation of this section for any claim: (i) initially submitted more than ninety (90) days after the service is rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider received the notice provided for in subsection (b) of this section; provided, this exception shall not apply in the event compliance is rendered impossible due to matters beyond the control of the health care provider and were not caused by the health care provider.

(3) No health care entity or health plan operating in the state shall be in violation of this section while the claim is pending due to a fraud investigation by a state or federal agency.

(4) No health care entity or health plan operating in the state shall be obligated under this section to pay interest to any health care provider or policyholder for any claim if the director of business regulation finds that the entity or plan is in substantial compliance with this section. A health care entity or health plan seeking such a finding from the director shall submit any documentation that the director shall require. A health care entity or health plan which is found to be in substantial compliance with this section shall thereafter submit any documentation that the director may require on an annual basis for the director to assess ongoing compliance with this section.

(5) A health care entity or health plan may petition the director for a waiver of the provision of this section for a period not to exceed ninety (90) days in the event the health care

entity or health plan is converting or substantially modifying its claims processing systems.

~~(f)~~ (h) For purposes of this section, the following definitions apply:

(1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or (iii) all services for one patient or subscriber within a bill or invoice.

(2) "Date of receipt" means the date the health care entity or health plan receives the claim whether via electronic submission or as a paper claim.

(3) "Health care entity" means a licensed insurance company or nonprofit hospital or medical or dental service corporation or plan or health maintenance organization, or a contractor as described in section 23-17.13-2(2), which operates a health plan.

(4) "Health care provider" means an individual clinician, either in practice independently or in a group, who provides health care services, and ~~otherwise referred to as a non-institutional provider~~ any health care facility, as defined in § 23-18-1.1 including any mental health and/or substance abuse treatment facility, physician, or other licensed practitioners identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.

(5) "Health care services" include, but are not limited to, medical, mental health, substance abuse, dental and any other services covered under the terms of the specific health plan.

(6) "Health plan" means a plan operated by a health care entity that provides for the delivery of health care services to persons enrolled in those plans through:

(i) Arrangements with selected providers to furnish health care services; and/or

(ii) Financial incentive for persons enrolled in the plan to use the participating providers and procedures provided for by the health plan.

(7) "Medically necessary" means services or supplies that are needed for the diagnosis or treatment of a medical condition and meet generally accepted standards of medical practice. For these purposes, "generally accepted standards of medical practice" means standards and guidelines that include, but are not limited to, lnterQual and other supporting information based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas, and any other relevant factors.

~~(7)~~ (8) "Policyholder" means a person covered under a health plan or a representative designated by that person.

~~(8)~~ (9) "Substantial compliance" means that the health care entity or health plan is processing and paying ninety-five percent (95%) or more of all claims within the time frame provided for in subsections (a) and (b) of this section.

~~(g)~~ (i) Any provision in a contract between a health care entity or a health plan and a health care provider which is inconsistent with this section shall be void and of no force and effect.

SECTION 2. Section 27-19-52 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" is hereby amended to read as follows:

27-19-52. Prompt processing of claims. -- (a) A health care entity or health plan operating in the state shall pay all complete claims for covered health care services submitted to the health care entity or health plan by a health care provider or by a policyholder within forty (40) calendar days following the date of receipt of a complete written claim or within thirty (30) calendar days following the date of receipt of a complete electronic claim. Each health plan shall establish a written standard defining what constitutes a complete claim and shall distribute this standard to all participating providers.

(b) If the health care entity or health plan denies or pends a claim, the health care entity or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing the health care provider or policyholder of any and all reasons for denying or pending the claim and what, if any, additional information is required to process the claim. No health care entity or health plan may limit the time period in which additional information may be submitted to complete a claim.

(c) Any claim that is resubmitted by a health care provider or policyholder shall be treated by the health care entity or health plan pursuant to the provisions of subsection (a) of this section.

(d) A health care entity or health plan which fails to reimburse the health care provider or policyholder after receipt by the health care entity or health plan of a complete claim within the required timeframes shall pay to the health care provider or the policyholder who submitted the claim, in addition to any reimbursement for health care services provided, interest which shall accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a complete written claim, and ending on the date the payment is issued to the health care provider or the policyholder.

(e)(1) A health care entity or health plan shall not deny payment for a claim for medically necessary inpatient services resulting from an emergency admission provided by a hospital solely on the basis that the hospital did not timely notify such health care entity or health plan that the services had been provided.

(2) Nothing in this subsection shall preclude a hospital and a health care entity or health

plan from agreeing to requirements for timely notification that medically necessary inpatient services resulting from an emergency admission have been provided and to a reduction in payment for failure to timely notify; provided, however that: (i) Any requirement for timely notification must provide for a reasonable extension of timeframes for notification for emergency services provided on weekends, state, or federal holidays, or during declared state or federally declared states of emergency; (ii) Any agreed to reduction in payment for failure to timely notify shall not exceed the lesser of two thousand dollars ($2,000) or twelve percent (12%) of the payment amount otherwise due for the services provided; and (iii) any agreed to reduction in payment for failure to timely notify shall not be imposed if the patient's insurance coverage could not be determined by the hospital after reasonable efforts at the time the inpatient services were provided.

(f) Except where the parties have developed a mutually agreed upon process for the reconciliation of coding disputes that includes a review of submitted medical records to ascertain the correct coding for payment, a hospital shall, upon receipt of payment of a claim for which payment has been adjusted based on a particular coding to a patient including the assignment of diagnosis and procedure, have the opportunity to submit the affected claim with medical records supporting the hospital's initial coding of the claim within thirty (30) days of receipt of payment. Upon receipt of such medical records, the health care entity or health plan shall review such information to ascertain the correct coding for payment and process the claim in accordance with the time frames set forth in subsection (a) of this section. In the event the health care entity or health plan processes the claim consistent with its initial determination, such decision shall be accompanied by a detailed statement in plain language of the health care entity or health plan setting forth the specific reasons why the initial adjustment was appropriate. A health care entity or health plan that increases the payment based on the information submitted by the hospital, but fails to do so in accordance with the timeframes set forth in subsection (a) of this section, shall pay to the hospital interest on the amount of such increase at the rate set pursuant to subsection (d) of this section. Neither the initial or subsequent processing of the claim by the health care entity or health plan shall be deemed an adverse determination if based solely on a coding determination. Nothing in this subsection shall apply to those instances in which the insurer or organization, or corporation has a reasonable suspicion of fraud or abuse.

~~(e)~~ (g) Exceptions to the requirements of this section are as follows:

(1) No health care entity or health plan operating in the state shall be in violation of this section for a claim submitted by a health care provider or policyholder if:

(i) Failure to comply is caused by a directive from a court or federal or state agency;

(ii) The health care provider or health plan is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(iii) The health care entity or health plan's compliance is rendered impossible due to matters beyond its control that are not caused by it.

(2) No health care entity or health plan operating in the state shall be in violation of this section for any claim: (i) initially submitted more than ninety (90) days after the service is rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider received the notice provided for in section 27-18-61(b); provided, this exception shall not apply in the event compliance is rendered impossible due to matters beyond the control of the health care provider and were not caused by the health care provider.

(3) No health care entity or health plan operating in the state shall be in violation of this section while the claim is pending due to a fraud investigation by a state or federal agency.

(4) No health care entity or health plan operating in the state shall be obligated under this section to pay interest to any health care provider or policyholder for any claim if the director of the department of business regulation finds that the entity or plan is in substantial compliance with this section. A health care entity or health plan seeking such a finding from the director shall submit any documentation that the director shall require. A health care entity or health plan which is found to be in substantial compliance with this section shall after this submit any documentation that the director may require on an annual basis for the director to assess ongoing compliance with this section.

(5) A health care entity or health plan may petition the director for a waiver of the provision of this section for a period not to exceed ninety (90) days in the event the health care entity or health plan is converting or substantially modifying its claims processing systems.

~~(f)~~ (h) For purposes of this section, the following definitions apply:

(1) "Claim" means:

(i) A bill or invoice for covered services;

(ii) A line item of service; or

(iii) All services for one patient or subscriber within a bill or invoice.

(2) "Date of receipt" means the date the health care entity or health plan receives the claim whether via electronic submission or has a paper claim.

(3) "Health care entity" means a licensed insurance company or nonprofit hospital or medical or dental service corporation or plan or health maintenance organization, or a contractor as described in section 23-17.13-2(2), that operates a health plan.

(4) "Health care provider" means an individual clinician, either in practice independently

or in a group, who provides health care services, and ~~referred to as a non-institutional provider~~ any health care facility, as defined in § 27-19-1 including any mental health and/or substance abuse treatment facility, physician, or other licensed practitioners identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.

(5) "Health care services" include, but are not limited to, medical, mental health, substance abuse, dental and any other services covered under the terms of the specific health plan.

(6) "Health plan" means a plan operated by a health care entity that provides for the delivery of health care services to persons enrolled in those plans through:

(i) Arrangements with selected providers to furnish health care services; and/or

(ii) Financial incentive for persons enrolled in the plan to use the participating providers and procedures provided for by the health plan.

(7) "Medically necessary" means services or supplies that are needed for the diagnosis or treatment of a medical condition and meet generally accepted standards of medical practice. For these purposes, "generally accepted standards of medical practice" means standards and guidelines that include, but are not limited to, lnterQual and other supporting information based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas, and any other relevant factors.

~~(7)~~ (8) "Policyholder" means a person covered under a health plan or a representative designated by that person.

~~(8)~~ (9) "Substantial compliance" means that the health care entity or health plan is processing and paying ninety-five percent (95%) or more of all claims within the time frame provided for in section 27-18-61(a) and (b).

~~(g)~~ (i) Any provision in a contract between a health care entity or a health plan and a health care provider which is inconsistent with this section shall be void and of no force and effect.

SECTION 3. Section 27-20-47 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" is hereby amended to read as follows:

27-20-47. Prompt processing of claims. -- (a) A health care entity or health plan operating in the state shall pay all complete claims for covered health care services submitted to the health care entity or health plan by a health care provider or by a policyholder within forty (40) calendar days following the date of receipt of a complete written claim or within thirty (30) calendar days following the date of receipt of a complete electronic claim. Each health plan shall establish a written standard defining what constitutes a complete claim and shall distribute the

standard to all participating providers.

(b) If the health care entity or health plan denies or pends a claim, the health care entity or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing the health care provider or policyholder of any and all reasons for denying or pending the claim and what, if any, additional information is required to process the claim. No health care entity or health plan may limit the time period in which additional information may be submitted to complete a claim.

(c) Any claim that is resubmitted by a health care provider or policyholder shall be treated by the health care entity or health plan pursuant to the provisions of subsection (a) of this section.

(d) A health care entity or health plan which fails to reimburse the health care provider or policyholder after receipt by the health care entity or health plan of a complete claim within the required timeframes shall pay to the health care provider or the policyholder who submitted the claim, in addition to any reimbursement for health care services provided, interest which shall accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a complete written claim, and ending on the date the payment is issued to the health care provider or the policyholder.

(e)(1) A health care entity or health plan shall not deny payment for a claim for medically necessary inpatient services resulting from an emergency admission provided by a hospital solely on the basis that the hospital did not timely notify such health care entity or health plan that the services had been provided.

(2) Nothing in this subsection shall preclude a hospital and a health care entity or health plan from agreeing to requirements for timely notification that medically necessary inpatient services resulting from an emergency admission have been provided and to a reduction in payment for failure to timely notify; provided, however that: (i) Any requirement for timely notification must provide for a reasonable extension of timeframes for notification for emergency services provided on weekends, state, or federal holidays, or during declared state or federally declared states of emergency; (ii) Any agreed to reduction in payment for failure to timely notify shall not exceed the lesser of two thousand dollars ($2,000) or twelve percent (12%) of the payment amount otherwise due for the services provided; and (iii) Any agreed to reduction in payment for failure to timely notify shall not be imposed if the patient's insurance coverage could not be determined by the hospital after reasonable efforts at the time the inpatient services were provided.

(f) Except where the parties have developed a mutually agreed upon process for the reconciliation of coding disputes that includes a review of submitted medical records to ascertain the correct coding for payment, a hospital shall, upon receipt of payment of a claim for which payment has been adjusted based on a particular coding to a patient including the assignment of diagnosis and procedure, have the opportunity to submit the affected claim with medical records supporting the hospital's initial coding of the claim within thirty (30) days of receipt of payment. Upon receipt of such medical records, the health care entity or health plan shall review such information to ascertain the correct coding for payment and process the claim in accordance with the time frames set forth in subsection (a) of this section. In the event the health care entity or health plan processes the claim consistent with its initial determination, such decision shall be accompanied by a detailed statement in plain language of the health care entity or health plan setting forth the specific reasons why the initial adjustment was appropriate. A health care entity or health plan that increases the payment based on the information submitted by the hospital, but fails to do so in accordance with the timeframes set forth in subsection (a) of this section, shall pay to the hospital interest on the amount of such increase at the rate set pursuant to subsection (d) of this section. Neither the initial or subsequent processing of the claim by the health care entity or health plan shall be deemed an adverse determination if based solely on a coding determination. Nothing in this subsection shall apply to those instances in which the insurer or organization, or corporation has a reasonable suspicion of fraud or abuse.

~~(e)~~ (g) Exceptions to the requirements of this section are as follows:

(1) No health care entity or health plan operating in the state shall be in violation of this section for a claim submitted by a health care provider or policyholder if:

(i) Failure to comply is caused by a directive from a court or federal or state agency;

(ii) The health care entity or health plan is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(iii) The health care entity or health plan's compliance is rendered impossible due to matters beyond its control that are not caused by it.

(2) No health care entity or health plan operating in the state shall be in violation of this section for any claim: (i) initially submitted more than ninety (90) days after the service is rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider received the notice provided for in section 27-18-61(b); provided, this exception shall not apply in the event compliance is rendered impossible due to matters beyond the control of the health care provider and were not caused by the health care provider.

(3) No health care entity or health plan operating in the state shall be in violation of this

section while the claim is pending due to a fraud investigation by a state or federal agency.

(4) No health care entity or health plan operating in the state shall be obligated under this section to pay interest to any health care provider or policyholder for any claim if the director of the department of business regulation finds that the entity or plan is in substantial compliance with this section. A health care entity or health plan seeking such a finding from the director shall submit any documentation that the director shall require. A health care entity or health plan which is found to be in substantial compliance with this section shall after this submit any documentation that the director may require on an annual basis for the director to assess ongoing compliance with this section.

(5) A health care entity or health plan may petition the director for a waiver of the provision of this section for a period not to exceed ninety (90) days in the event the health care entity or health plan is converting or substantially modifying its claims processing systems.

~~(f)~~ (h) For purposes of this section, the following definitions apply:

(1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or (iii) all services for one patient or subscriber within a bill or invoice.

(2) "Date of receipt" means the date the health care entity or health plan receives the claim whether via electronic submission or has a paper claim.

(3) "Health care entity" means a licensed insurance company or nonprofit hospital or medical or dental service corporation or plan or health maintenance organization, or a contractor as described in section 23-17.13-2(2), that operates a health plan.

(4) "Health care provider" means an individual clinician, either in practice independently or in a group, who provides health care services, and ~~referred to as a non-institutional provider~~ any health care facility, as defined in § 27-20-1 including any mental health and/or substance abuse treatment facility, physician, or other licensed practitioners identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.

(5) "Health care services" include, but are not limited to, medical, mental health, substance abuse, dental and any other services covered under the terms of the specific health plan.

(6) "Health plan" means a plan operated by a health care entity that provides for the delivery of health care services to persons enrolled in the plan through:

(i) Arrangements with selected providers to furnish health care services; and/or

(ii) Financial incentive for persons enrolled in the plan to use the participating providers and procedures provided for by the health plan.

(7) "Medically necessary" means services or supplies that are needed for the diagnosis or treatment of a medical condition and meet generally accepted standards of medical practice. For

these purposes, "generally accepted standards of medical practice" means standards and guidelines that include, but are not limited to, lnterQual and other supporting information based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas, and any other relevant factors.

~~(7)~~ (8) "Policyholder" means a person covered under a health plan or a representative designated by that person.

~~(8)~~ (9) "Substantial compliance" means that the health care entity or health plan is processing and paying ninety-five percent (95%) or more of all claims within the time frame provided for in section 27-18-61(a) and (b).

~~(g)~~ (i) Any provision in a contract between a health care entity or a health plan and a health care provider which is inconsistent with this section shall be void and of no force and effect.

SECTION 4. Section 27-41-64 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" is hereby amended to read as follows:

27-41-64. Prompt processing of claims. -- (a) A health care entity or health plan operating in the state shall pay all complete claims for covered health care services submitted to the health care entity or health plan by a health care provider or by a policyholder within forty (40) calendar days following the date of receipt of a complete written claim or within thirty (30) calendar days following the date of receipt of a complete electronic claim. Each health plan shall establish a written standard defining what constitutes a complete claim and shall distribute this standard to all participating providers.

(b) If the health care entity or health plan denies or pends a claim, the health care entity or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing the health care provider or policyholder of any and all reasons for denying or pending the claim and what, if any, additional information is required to process the claim. No health care entity or health plan may limit the time period in which additional information may be submitted to complete a claim.

(c) Any claim that is resubmitted by a health care provider or policyholder shall be treated by the health care entity or health plan pursuant to the provisions of subsection (a) of this section.

(d) A health care entity or health plan which fails to reimburse the health care provider or policyholder after receipt by the health care entity or health plan of a complete claim within the required timeframes shall pay to the health care provider or the policyholder who submitted the

claim, in addition to any reimbursement for health care services provided, interest which shall accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a complete written claim, and ending on the date the payment is issued to the health care provider or the policyholder.

(e)(1) A health care entity or health plan shall not deny payment for a claim for medically necessary inpatient services resulting from an emergency admission provided by a hospital solely on the basis that the hospital did not timely notify such health care entity or health plan that the services had been provided.

(2) Nothing in this subsection shall preclude a hospital and a health care entity or health plan from agreeing to requirements for timely notification that medically necessary inpatient services resulting from an emergency admission have been provided and to a reduction in payment for failure to timely notify; provided, however that: (i) Any requirement for timely notification must provide for a reasonable extension of timeframes for notification for emergency services provided on weekends, state, or federal holidays, or during declared state or federally declared states of emergency; (ii) Any agreed to reduction in payment for failure to timely notify shall not exceed the lesser of two thousand dollars or twelve percent (12%) of the payment amount otherwise due for the services provided; and (iii) Any agreed to reduction in payment for failure to timely notify shall not be imposed if the patient's insurance coverage could not be determined by the hospital after reasonable efforts at the time the inpatient services were provided.

(f) Except where the parties have developed a mutually agreed upon process for the reconciliation of coding disputes that includes a review of submitted medical records to ascertain the correct coding for payment, a hospital shall, upon receipt of payment of a claim for which payment has been adjusted based on a particular coding to a patient including the assignment of diagnosis and procedure, have the opportunity to submit the affected claim with medical records supporting the hospital's initial coding of the claim within thirty (30) days of receipt of payment. Upon receipt of such medical records, the health care entity or health plan shall review such information to ascertain the correct coding for payment and process the claim in accordance with the time frames set forth in subsection (a) of this section. In the event the health care entity or health plan processes the claim consistent with its initial determination, such decision shall be accompanied by a detailed statement in plain language of the health care entity or health plan setting forth the specific reasons why the initial adjustment was appropriate. A health care entity or health plan that increases the payment based on the information submitted by the hospital, but

fails to do so in accordance with the timeframes set forth in subsection (a) of this section, shall pay to the hospital interest on the amount of such increase at the rate set pursuant to subsection (d) of this section. Neither the initial or subsequent processing of the claim by the health care entity or health plan shall be deemed an adverse determination if based solely on a coding determination. Nothing in this subsection shall apply to those instances in which the insurer or organization, or corporation has a reasonable suspicion of fraud or abuse.

~~(e)~~ (g) Exceptions to the requirements of this section are as follows:

(1) No health care entity or health plan operating in the state shall be in violation of this section for a claim submitted by a health care provider or policyholder if:

(i) Failure to comply is caused by a directive from a court or federal or state agency;

(ii) The health care entity or health plan is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(iii) The health care entity or health plan's compliance is rendered impossible due to matters beyond its control, which are not caused by it.

(2) No health care entity or health plan operating in the state shall be in violation of this section for any claim: (i) initially submitted more than ninety (90) days after the service is rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider received the notice provided for in section 27-18-61(b); provided, this exception shall not apply in the event compliance is rendered impossible due to matters beyond the control of the health care provider and were not caused by the health care provider.

(3) No health care entity or health plan operating in the state shall be in violation of this section while the claim is pending due to a fraud investigation by a state or federal agency.

(4) No health care entity or health plan operating in the state shall be obligated under this section to pay interest to any health care provider or policyholder for any claim if the director of the department of business regulation finds that the entity or plan is in substantial compliance with this section. A health care entity or health plan seeking that finding from the director shall submit any documentation that the director shall require. A health care entity or health plan which is found to be in substantial compliance with this section shall submit any documentation the director may require on an annual basis for the director to assess ongoing compliance with this section.

(5) A health care entity or health plan may petition the director for a waiver of the provision of this section for a period not to exceed ninety (90) days in the event the health care entity or health plan is converting or substantially modifying its claims processing systems.

~~(f)~~ (h) For purposes of this section, the following definitions apply:

(1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or (iii) all services for one patient or subscriber within a bill or invoice.

(2) "Date of receipt" means the date the health care entity or health plan receives the claim whether via electronic submission or as a paper claim.

(3) "Health care entity" means a licensed insurance company or nonprofit hospital or medical or dental service corporation or plan or health maintenance organization, or a contractor as described in section 23-17.13-2(2) that operates a health plan.

(4) "Health care provider" means an individual clinician, either in practice independently or in a group, who provides health care services, and ~~is referred to as a non-institutional provider~~ health care facility, as defined in § 27-41-2 including any mental health and/or substance abuse treatment facility, physician, or other licensed practitioners identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.

(5) "Health care services" include, but are not limited to, medical, mental health, substance abuse, dental and any other services covered under the terms of the specific health plan.

(6) "Health plan" means a plan operated by a health care entity that provides for the delivery of health care services to persons enrolled in the plan through:

(i) Arrangements with selected providers to furnish health care services; and/or

(ii) Financial incentive for persons enrolled in the plan to use the participating providers and procedures provided for by the health plan.

(7) "Medically necessary" means services or supplies that are needed for the diagnosis or treatment of a medical condition and meet generally accepted standards of medical practice. For these purposes, "generally accepted standards of medical practice" means standards and guidelines that include, but are not limited to, lnterQual and other supporting information based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas, and any other relevant factors.

~~(7)~~ (8) "Policyholder" means a person covered under a health plan or a representative designated by that person.

~~(8)~~ (9) "Substantial compliance" means that the health care entity or health plan is processing and paying ninety-five percent (95%) or more of all claims within the time frame provided for in section 27-18-61(a) and (b).

~~(g)~~ (i) Any provision in a contract between a health care entity or a health plan and a health care provider which is inconsistent with this section shall be void and of no force and effect.

SECTION 5. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE

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This act would address the resolution of disputes which occur between health care providers and health insurance companies regarding notification requirements prior to treatment and disputes regarding the nature, cost and justification for services provided, a more specific framework for dispute resolution is created.

This act would take effect upon passage.

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